The Manitoba Medical Review

Vol. 23 WINNIPEG, DECEMBER, 1943 No. 12

The Practice of Medicine in China, Old and New

by T. H. WILLIAMS, M.D.,C.M., D.T.M. & H. (Eng.)
Professor of Pathology, West China Union University

China was for many centuries one of the leading countries of the world in the practice of medicine. Shen Nung and Huang Ti, emperors of China as early as 2700 B.C. wrote treatises on the medicinal use of herbs. Shen Nung personally tasted and therapeutically tested many thousands of herbs. In the third century the book Pen Tsao was written on Materia Medica describing the use of many remedies good, bad and indifferent. The Synopsis of Ancient Herbs was written in the 16th century by Li Shi Chen in which he described fully the botanical appearance, preparation, and use of 1892 drugs. By Imperial decree in the 18th century The Imperial Collection of Chinese Books of Medicine was compiled comprising 196 volumes containing many good remedies and many fantastic and useless ones. Into this store of ancient lore capable Chinese research scholars have been enquiring in recent years, sifting the wheat from the chaff.

Inoculation for protection against smallpox by using human smallpox virus from person to person was practiced in China centuries before it was introduced through Arabia and Turkey and then to Europe in 1717 by Lady Mary Wortley Montague.

Concerning the etiology of disease in China as in many other lands, worms which infested the body were believed to be the underlying cause of many maladies whereas, as a matter of fact, the most easily seen ones have little effect on the human host. This belief in worms as a cause of disease is readily explained by the fact that the worm is visible evidence of something infesting the body that ought not to be there. Worms are universally common in Oriental countries. We read in our sacred writings "Where their worm dieth not and their fire is not quenched." In 1938 I made a survey of intestinal parasites among the inhabitants of a rural area in western China. In examination of over 700 persons we found that the common round worm Ascaris was harbored by over 90% of the farmer, priest, and coolie population of that area. Hookworm was also present in over 25% but usually not in sufficient numbers to cause symptoms.

Early beliefs concerning the disease were strongly anamistic and closely connected with the Yin and the Yang. These are supposed to be the two opposing or complementary basic elements which pervade all nature and must always be harmoniously balanced. Yang is the male, positive, principle or element as seen in light, life, warmth, etc. Yin is the female or negative element as evidenced by darkness, cold, death, etc. And in a like manner all nature is supposed to be made up of combinations of these. In the body when they are properly balanced health and vigor and placidity results but when one or the other is in excess bodily derangements, weaknesses, and excitements result. For instance the Yang principle in excess was held responsible for sthenic inflammatory processes while the Yin was charged with causing asthenic typhoidal types of fevers, etc.

Exorcism or Magic has also long had a strong influence in Oriental healing and is akin to the lucky charms and other superstitions seen everywhere and especially in primitive peoples. This exorcism was widely practiced by Buddhism and other religions and we have often been kept awake at night in China by the devil-driving priests with their instruments of cymbals, drums, pipes, gongs, and chimes and firecrackers keeping up a continual din all night long driving away the evil spirits held responsible for disease and incidentally driving away all sleep for a radius of some distance. Prayers and offerings were also made to the God of Healing called Yao Dai Fu in the temples. Here prescriptions are numbered and the patient after paying his respects to the god drew by lot a bamboo tally stick on which was the number of the prescription the god regarded as correct for him. He then took this tally to the dispenser priest who for a consideration handed out the corresponding mixture.

Needling or acupuncture was an outgrowth from this belief of demons dwelling in the body and causing disease. So needles were plunged into the body to let out the evil spirits and this was done in 367 specific locations on the body for relief from ailments whose spirit resided there. Many of these areas are on the face, neck, arms, and legs and they are chiefly on exposed or easily exposable parts of the body. Serious inflammation often resulted from the introduction of these unsterilized needles and was always blamed to the wrong devil. On the other hand its use in mumps and other evanescent swellings which subsequently subsided received as favorable free publicity in the Chinese tea shops as the fortunate recoveries under irregular practitioners get in other lands over the back stoop and garden fence.

Somewhat similar was the use of medicated cotton, silk, or other fibres introduced deeply into tumor

growths and left there. These produced inflammatory reactions and the formation of an abscess which destroyed more or less of the tumor if not the entire patient. Such untoward results coupled with the absence of antiseptic and aseptic methods made all surgery unpopular with the patients and heroic for the practitioner against whom stern vengeance was likely to be taken. Consequently the medical profession of China was almost wholly without surgery until Western teaching introduced it.

Counter irritation is widely used in China and a very common form is the repeated squeezing and pulling and pinching of the skin between the tea-moistened knuckles until a purple area is produced resembling a bruise. This is done in certain areas for certain ailments as: behind the angle of the eye for conjunctivitis and other eye conditions; above the root of the nose for headache; along the sides of the neck for fevers; and over the muscles for rheumatic-type pains, sprains, etc. Dried beetles, mustard and other counter irritants are also used. The most heroic examples of the use of counter irritants I have seen were among the Koreans who used small domes of charcoal set alight and applied to the surface of the abdomen for abdominal pain. By the time these have burned down the patient is likely to have forgotten his belly ache as he has something else to think about.

Topical applications for ulcers and skin inflammations are made of fresh leaves, herbs, kaolin, and other earths and substances. Possibly derived from the Hindu reverence of the cow and her five sacred products is the use I have seen made of fresh cow dung as a poultice material. In this connection also I have seen the freshly killed flesh of frogs, cold blooded animals, used as a cooling eye application in conjunctivitis which is very common and called "Sa yen," sand eye, in China. Cases of migration of worm parasites from the frog flesh into the conjunctival sac and penetration into the tissues around the eye have been seen. This parasite is the larval Sparganum of which the fully developed adult is a tapeworm. Hot ashes are a frequently used application to bleeding wounds to arrest haemorrhage and ought at least to be fairly sterile.

Animal organotherapy has long been practiced in China and similar to our own use of thyroid tablets here has been the use of sheeps' thyroids for cretinism in China. However, along with some undoubtedly beneficial uses there are many fanciful and useless practices. For instance, the giving of powdered tiger's tooth for nervous timid patients on the reasoning that as the tiger is a fearless animal it must transfer courage to the patient; giving elephant's skin for skin diseases because the elephant's skin is so resistant to injury; giving dried monkey joints to patients with arthritis because the monkey is so agile, and so on. Perhaps a little more therapeutically defendable is the giving of powdered new deer horn to patients with anaemia, for here there will be some calcium and iron at least. Snakes are highly prized for medicinal properties.

Present-day practitioners are of several types but chiefly known as Old Style Practitioners and Western Style Practitioners. Many of the Old Style doctors are herbalists and prescribe herbs, barks, roots, leaves, fruits, and stems of medicinal plants which are more abundant in China than anywhere else. Many of these are potent drugs and so skillful have the better class old style practitioners become in compounding these that they are preferred by a majority of the population even today for the treatment of internal maladies. The common saying is, "Call an old style doctor for internal diseases, and a Western style one for surgery. In olden times these remedies were prescribed singly or in small combinations but today most of the prescriptions are a "shot gun" combination of many things. The herbalist's place of business is an open-fronted shop with the walls all hung with dried roots, herbs, etc. and with drawers filled with ground-up powders. The patient is examined on the spot or a relative or friend details the symptoms and the herbalist prescribes the appropriate remedy with directions as to how to make the infusion or powder mixture. The dose is always in a large quantity of fluid and many persons look with disfavor on our style of giving tablets or concentrated fluid mixtures. Some such patients have been known to drink the whole bottle on the reasoning that if a little is good a lot is much better and I have seen some nasty reactions occur from this being done.

Medical education has always been encouraged by the present Government of China and they very wisely arranged for the withdrawal inland of the various colleges. These colleges with the universities they are parts of are now located in various cities in Free China and graduating full classes each year. Students leave their homes in occupied China as well as Free China and find their way through the Jap thinly-held garrison lines and enroll in the Colleges in West China. For instance, Peking Union Medical College, the Rockefeller institution of North China was closed by the enemy as soon as war was declared on England and the United States. Some of the teachers and over 60 of the students are now enrolled in West China Union University College of Medicine. There are now four medical colleges in the city of Chengtu. Classes average from 20 to 100 students per year in these four colleges. They all require two years premedical science of university grade and five years of medicine with a year of satisfactory interneship. The Government of China further requires a satisfactory Thesis from each student before he or she can receive national registration. The standard is high and the graduates make very good physicians. Students are from one-fourth to one-third women and there is a great field for women doctors in the homes of China.

Preliminary Report on Blood Studies on Diabetic Retinitis

by DR. A. HOLLENBERG

Since the recent work on the blood clotting mechanism which was stimulated by the discovery of Vitamin K and the preparation of anti-coagulants heparin and dicoumarol, the subject of localized haemorrhage as exhibited in diabetic retinitis comes under review.

It has long been recognized that diabetic retinitis uncomplicated by hypertension and arteriosclerosis occurs sporadically in diabetic subjects who were perfectly balanced according to modern accepted standards. Frequently model subjects of diabetic management develop diabetic retinitis whereas those who are poorly balanced and who often show ketosis are not prone to this complication in the proportion which one would expect if ketosis alone were the chief causative factor. We further know that once the condition occurs it may subside and recur again in a manner totally unrelated to the diabetic condition. It occurs as frequently in mild diabetes as it does in severe cases where the complication of hypertension and arteriosclerosis does not exist. One must differentiate between the vascular changes which occur in a diabetic with arteriosclerosis and hypertension and those which occur in a diabetic without these complications. In the pure diabetic retinitis the haemorrhage and retinitis occur towards the periphery of the smaller anterioles and often in areas which appear free from visible vessels, whereas the haemorrhagic manifestations of hypertensive heart disease and arteriosclerosis occur in relation to the vascular tree of the retina. It is not uncommon in diabetes to find a combination of the two conditions and it is then difficult to assess the amount of retinal damage which should be ascribed to each of the causative factors.

In addition to the observations made above, it has been noted that the pure diabetic retinitis occurs in bouts at varying intervals of time, with each successive attack producing further damage to the fields of vision. In the acute stages of this disease it is frequently found that in addition to the localized haemorrhagic patches in the retinae, there is also an associated papilloedema which regresses in time, usually a few weeks, and there is some improvement of in the vision as compared with the vision at the time of the active phase of the disease, but each successive attack leaves its permanent mark by reduction of vision or upon the fields of vision.

In view of the above considerations it was difficult to escape the conclusion that diabetic retinitis was not an isolated condition but was to be considered as a haemorrhagic manifestation associated with diabetes mellitus and unrelated to the accustomed metabolic considerations which we have concentrated upon the concept of diabetes heretofore. It was with this in mind that the examination of the blood clotting mechanism as it related to the subject under discussion, was undertaken.

The recent large amount of work that has been done relative to the elaboration of the physiology of Vitamin K and heparin has shown that the old method of estimating blood clotting time by collecting the blood in a capillary tube or even in a small test tube, is not very accurate nor very sensitive. The latter methods do have their place, but when they manifest prolonged clotting time, the damage to the blood clotting mechanism is already very severe and sometimes irreversible. It is as if we were to gauge diabetic acidosis by the degree of coma rather than by the recognition in the urine of acetone and diacetic acid. The prothrombin time estimation is a much more sensitive indication of disturbed clotting power of the blood. This has now amply been demonstrated clinically in the study of haemorrhagic tendencies in jaundice and in the clinical control of dosage of heparin and dicoumarol.

The seat of protein production and control lies in the liver. The factors that have to do with blood clotting are protein in nature with the possible exception of calcium. It is obvious then that any liver disturbance which is severe enough will produce changes in the protein synthesis and proportionment. This has been amply demonstrated in jaundice of hepatic origin. Of the proteins which are most easily disturbed, prothrombin takes an early place and prothrombin time has not been accepted as an estimate of liver function and damage.

Recent studies by Soskin at Michael Reese Hospital have definitely shown that diabetes mellitus is in many cases caused by hepatic disfunction alone or by hepatic dysfunction produced secondary to pancreatic (islet tissue) insufficiency. In many cases the liver is more at fault in the degree of diabetes than the islet deficiency.

By studying the prothrombin time of diabetes in general it has been found that a large percentage have a diminished amount of prothrombin in their blood (*i.e.*, prolonged prothrombin time). A lesser percentage show in addition a decreased amount of total blood protein, far greater than would be accounted for by the decrease in prothrombin. It is evident then that diabetes mellitus is a metabolic disease affecting not only carbohydrate and fat metabolism but also protein metabolism and by the latter disturbance will show its effect on blood clotting. This effect has long been recognized by surgeons who have learned that diabetics frequently bleed after operation and by the otolaryngologist who has known of the severity and

difficulty in controlling of epistaxis and post-tonsillectomy haemorrhage in a diabetic. Similarly the bleeding associated with venal insufficiency is also to some great degree due to liver parenchymal damage caused by the toxic substances retained in uraemia.

Regarding diabetic retinitis it has been shown by prothrombin studies in 18 cases that in the acute phase of the disease that there is a definite diminution in the amount of prothrombin in the blood and frequently a diminished total blood protein as well. By instituting the accepted measures of increasing prothrombin in the blood, namely Vitamin K injections, blood transfusions. increased protein intake by mouth, and in some cases liver extract injections, the active phase of diabetic retinitis can be shortened to days instead of weeks and the sudden improvement at times borders on the spectacular. It must be pointed out that diabetic retinitis is punctuated by exacerbations and remissions and it is only during the exacerbations that the prothrombin time will be the indication for active treatment. In the remissions one may only find a decrease in the total blood proteins and a decreased or normal prothrombin time.

In summing up one would say that diabetic retinitis is a complication of liver damage associated with diabetes mellitus. It is a haemorrhagic disease due to deficiency in production of the proteins associated with blood clotting. As the function of the liver varies these proteins will vary and will cause the exacerbations and remissions which we know occur. The treatment of the condition at the time of crisis is the same as for any other haemorrhagic manifestation associated with prothrombin deficiency. In the periods of remission the management of the diabetic must be controlled from the protein point of view as well as from the glucose and fat factors. It may be that the protein requirements of some diabetics are greater than those dictated by nitrogenous equilibrium alone. The final criteria must be the total blood protein and the prothrombin content of the blood, as well as a normal blood sugar and normal blood fat.

The Conservative Treatment of Acute Osteomyelitis

E. S. James, F.R.C.S. (Eng.)

Until a very short time ago the accepted treatment for acute osteomyelitis was early operation. This consisted of early incision of the periosteum, accompanied by drilling a few small holes through the cortex if a sub pereosteal abscess was not encountered, and incorporating the limb in a plaster cast, ensuring complete rest and preventing the irritation of frequent change of dressings.

No one surgeon sees a large number of acute cases so it took many years to assess the value of this procedure. It became obvious that there were many local recurrences, that secondary foci developed in other bones, and the mortality rate was high (20%). Cases in which the active treatment was delayed for some reason, seemed on the whole to have progressed more favourably, and a lowered mortality rate was associated with them. It has also been pointed out that early operation does not tend to decrease the local extent of the disease.

Wilensky of New York states that foci of osteomyelitis may subside without going on to pus formation and sequestrae may and do become revascularized and reincorporated, as does a bone graft. Several such cases have been noted in this small series. Where no pus formation occurs, there are no radiological changes evident and one hesitates to report such cases as there is no proof that they were cases of osteomyelitis (clavicle—hip, etc.).

Where the focus of infection is in a peripheral bone as the tibia or radius or ulna the correct localization of the disease can be made early. Dr. Gibson points out that this is not so where the pelvic or shoulder girdle is affected. In these cases early operation over the supposedly diseased part fails to disclose an abscess, but several days later it may point in quite a different site. One such case was a boy 21 years of age who came into the Winnipeg General Hospital on October 17th, 1939. He had injured his right shoulder ten days previously. Pain increased, and on admission his temperature was 104. An X-ray was negative. He was kept in bed, fomentations were applied and operation was delayed because of failure to localize the site of the infection. However, on October 23rd he was taken to the operating room where under a general anaesthetic an aspirating needle was inserted in several places about the shoulder. Two incisions in the supra and infra spinous fossae were made, splitting the muscles down to the bone, but no pus was encountered. He was given Dagenan and later sulphanilamide as he did not tolerate the former. An X-ray on November 3rd disclosed an osteomyelitis of the neck, coracoid and axillary border of the scapula. The wounds healed without suppuration, his temperature subsided and he steadily improved. He has been well ever since. A similar case involving the acetabulum never was operated upon but resolved in a similar manner.

It was decided that all cases of osteomyelitis should be tried with conservative treatment, using sulphathiozal, rest and heat. Sulphathiozal prevents the multiplication of streptococci and staphylococci and so allows the natural forces of the body to destroy the organisms more readily. The blood stream is rendered sterile early and secondary foci are unlikely to appear. Abscesses also become sterile and are ab-

sorbed so that their drainage is unnecessary, scars are avoided and secondary infection does not occur. The drug is administered for several days after the temperature returns to normal although the dosage may be diminished. Rest and local heat diminishes the pain and accelerates recovery. Blood transfusions are very beneficial in sick toxic cases.

On February 24th, 1942, a boy 15 years of age was admitted complaining of pain in the lower end of his right femur, which began while he was walking three days previously. On admission his temperature was 104° and pain and local tenderness was acute above the medial aspect of his right knee. Fomentations were begun and sulphathiozal commenced. A blood culture of February 24th showed that staphylococcous aureus was the infecting organism. Two blood transfusions were given. His condition improved but the leg remained painful for several weeks. Fluctuation appeared to be present during the second week. but it was decided not to incise the abscess, as we had all seen appendiceal abscesses resolve, and also did not incise cold abscesses for fear of introducing a secondary organism. Secondary organisms we feel play a very important part in osteomyelitis, and especially in chronic osteomyelitis, and may be responsible for the chronicity of the infection. X-rays of the femur were negative until March 11th. By March 29th a suggestion of an intra medullary sequestrum could be made out. An X-ray taken in October 1942 showed a sclerotic femur with an apparently quiescent process. The sequestrum can still be seen plainly. He has been working without complaints ever since his discharge from hospital in April 1942. He was last seen in October 1942.

Numerous cases have been similarly treated. No acute case has been operated upon during the past two years. There have been no deaths and no case has developed a secondary focus, nor has there been a recurrence of inflammation in the primary focus up to the present time.

One child, 10 months of age, was brought in because of pain about her right wrist. This she had had for 10 days and it was accompanied by fever and loss of interest in her feedings. The wrist was swollen and tender and an X-ray revealed a destructive lesion in the head of the ulna. A tuberculin and Wasserman test were negative so the diagnosis of osteomyelitis was made. Sulphathiozal was administered and fomentations started. There was a prompt clinical improvement and a marked radiological change. Within six months the X-ray revealed the bone restored to normal.

One of our most recent cases had involvement of one tibia. This child made a very good progress on conservative treatment and was discharged symptomless. A series of X-rays reveal the steady improvement in the local lesion which accompanies the clinical picture.

It is too early and our series too small to be dogmatic about the results of conservative treatment. We feel that these steps are taken in the right direction. By controlling the bacteraemia early, secondary foci are less liable to develop. Abscesses disappear without being opened and so secondary infection does not occur. Sequestra are rendered aseptic and are absorbed or reconstituted into the healthy bone. We hope that recurrences will not develop and thereby eliminate the group of chronic osteomyelitis cases. Convalescence is shortened and no deformities or scars result. We hope that discharging sinuses and plaster casts may be looked upon as memories of the past.

Summary—

1. A group of cases of acute osteomyelitis has been treated without operation.
2. Treatment has consisted of rest, heat and sulphathiozal.
3. All have recovered, some completely.
4. No recurrences or secondary foci have occurred.
5. Experience has been sufficiently encouraging for us to continue the experiment.

Medical Happenings in December

DATE	TIME	PLACE	OCCASION
Thursday, 2nd	12:30 p.m.	Winnipeg General Hospital	Hospital Luncheon.
Monday, 6th	8:30 p.m.	St. Boniface Hospital	E.E.N.T. (W.M.S.) Meeting. Mr. Watson of Minneapolis will give a talk on the Audiometer
Thursday, 9th	12:30 p.m.	St. Boniface Hospital	Hospital Luncheon.
Tuesday, 12th	12:30 p.m.	Misericordia Hospital	Hospital Luncheon.
Thursday, 16th	12:30 p.m.	Winnipeg General Hospital	Hospital Luncheon.
Friday, 17th	8:15 p.m.	Medical College	W.M.S. Meeting
Tuesday, 21st	12:30 p.m.	Grace Hospital	Hospital Luncheon.
Saturday, 25th	All Day	A Very Merry Christmas to All!	

Hospital Luncheon Program Reports

Grace Hospital

The monthly Clinical Luncheon at Grace Hospital was held on Nov. 16. Dr. T. C. Brereton gave a very interesting and instructive paper on "Feeding Baby from Birth to the Second Month." Dr. Brereton emphasized the desirability of breast feeding; but where, for various reasons, this was impossible, he outlined in considerable detail the procedure he follows and the reason therefor.

The address was very ably discussed by Drs. Marlatt-Wildman, Gordon Chown and Bruce Chown, who were not in complete agreement with Dr. Brereton's conclusions. It was a very interesting meeting.

Our Clinical Luncheons are held on the 3rd Tuesday of each month (except the summer months) at 12:30 noon. All doctors, students or graduate nurses are welcome.

Misericordia Hospital

Pneumococcus Meningitis—Dr. McNulty

Dr. P. H. McNulty reported the case of a patient who developed pneumococcus meningitis following fracture of the skull. The patient did not do well on the sulpha drugs but showed remarkable improvement for a while when given penicillin. He did not, however, survive. This report will be given in complete detail in the next issue.

St. Boniface Hospital

Nov. 11, 1943.

Contributory National Health Insurance—Dr. McNulty

Dr. P. H. McNulty spoke at length upon the proposed Health Insurance Legislation. He dealt especially with those features of the Bill that, from the standpoint of the general practitioner, seemed most fraught with danger. He then, with the recent questionnaire as a basis, discussed the significance of each item. He was highly critical of certain suggested procedures and took particular offense at the introduction of the word "competence."

His presentation was so full and so excellent that he was given the full hour. The matter will, therefore, be continued at the next luncheon (Nov. 25th), when the other scheduled speakers will contribute.

St. Joseph's Hospital

Diabetes and Osteomyelitis—Drs. Dyma and Murray

Dr. Dyma reported the case of an elderly diabetic woman (a Christian Scientist) who entered hospital in coma with osteomyelitis. She had been aware of her diabetes for at least six years. The patient was brought out of coma and balanced, after which Dr. Murray operated upon the osteomyelitis which was at the lower end of the femur. In spite of many associated difficulties, such as stomatitis, leg ulcers, bed sores, anaemia and sub-sternal distress, she did reasonably well, but died suddenly, apparently from coronary occlusion. (According to the Christian Scientists, disease is "mortal error." This case proves it. The error lay in neglecting the diabetes and the result was mortal.)

Liver Juice in Amyloid Disease

Dr. Trainor spoke about the use of liver juice in this very fatal disorder. The rarity of amyloid disease, however, makes any remedy for it of comparatively minor importance, but liver juice is extremely valuable in the prevention of sulphanamide reactions and in the prevention of the liver deaths which follow operations upon the gall bladder. Its use in the preoperative care of "gall bladder patients" should be extended. The juice is very useful in all disorders associated with hypo proteinemia. Dr. Trainor mentioned a formula for a palatable preparation. (I asked Dr. Trainor to extend his notes into a paper but those of you who know Dr. Trainor will guess how far I got with that idea.)

Winnipeg General Hospital

Puzzling Case of Jaundice—Dr. H. D. Kitchen

Dr. Kitchen presented the case of a woman of 29 (and the mother of 6 children) who had suffered a two-weeks' illness characterized by fever, vomiting, lassitude and jaundice. The stools were pale and the urine contained bile. There was a second attack a month later during which time she had lost 34 lbs. Examination was essentially negative and the cause and nature of the jaundice were obscure. The very complete laboratory investigation gave evidence for and against every variety of jaundice. Prof. A. T. Cameron discussed at length and in detail the various liver function tests. Drs. Burns and A. C. Abbott dealt with the surgical aspects. The conclusion arrived at was that in this case both duct obstruction and liver damage existed, that the cause was probably malignancy and that laparotomy should be performed.

Sacral Tumor—Dr. K. R. Trueman

A sacral tumor as large as a foetal head, lobulated, barely movable, covered with shiny skin and palpable per rectum was shown by Dr. Trueman. The patient was a 24-year half-breed girl. Her chief symptom was obstipation. X-ray diagnosis was osteogenic sarcoma; biopsy showed it to be a myxo-chondro-sarcoma. Dr. Trueman dwelt upon the characters and malignancy of the tumor and discussed treatment. Inoperability of the growth left radiation as the only helpful measure with, however, its help very doubtful.

Operation of Blood Banks

Dr. Nicholson spoke of the work behind the organization and operation of this valuable adjunct to treatment. It would appear that the gratitude of the patient and his friends does not last long enough to replace the blood used. Doctors could help a great deal if they were to insist upon the blood being replaced as soon as possible after the transfusion.

Ununited Fracture of Femur Treated by High Ostetomy—C. A. James

According to Dr. James, non-union occurs in 25% of plaster-treated cases, and in from 10-15% of Smith-Peterson treated cases, of fractured femur. He advocated high osteotomy, a procedure which permits of weight-bearing within two months. He reported two cases so treated. Dr. Angus Murray, in his discussion, wondered if intro-chanteric pain was likely to occur later.

Victoria Hospital

Electrocardiograph Patterns in Myocardial Infractions—A. S. Shubin

Dr. Shubin showed, by means of slides, the typical patterns of anterior and posterior infarctions. He discussed the pathogenesis and clinical picture of infarction and described the laboratory procedures most useful in settling the diagnosis in doubtful cases. He stressed the significance and value of the urobilinogen test, especially in cases where pain is absent.

The second part of his paper dealt with treatment, and in particular with the use of morphine, papaverine and alcohol. He stressed the great value of alcohol by mouth and papaverine intravenously in grave cases. He spoke also about the prophylactic use of quinidine to prevent ventricular fibrillation.

Personal Notes and Social News

Surgeon-Lieutenant Murray McLandress, R.C.N.V.R., second son of Mr. and Mrs. Wallace McLandress of Winnipeg, was married November 20th at Port Arthur, Ont., to Ruth, daughter of Mr. and Mrs. W. F. Elliott of Port Arthur, Ont. After the wedding, the couple left for Toronto, Ont.

◈ ◈

Dr. L. H. Wettlaufer, '41 of Fort San, Sask., elder son of Mr. and Mrs. R. Wettlaufer of Yellowgrass, Sask., is engaged to marry Christina Isabel, only daughter of Dr. and Mrs. J. A. Swanson. The wedding to take place December 15th.

◈ ◈

Pte. Jamie H. W. Hutchinson, R.C.A.M.C., is to be married December 27th in the chapel at McMaster University, Hamilton, Ont., to Edna, daughter of Dr. and Mrs. Henry Maxwell Morrow of Dundas, Ont. Pte. Hutchinson is completing his studies in his final year of medicine at Manitoba University.

◈ ◈

Lieut. James Rosslyn Mitchell, son of Dr. Ross Mitchell, has been promoted to the rank of Captain in the R.C.A.M.C.

◈ ◈

Dr. V. F. Bachynski was elected president of the Trident Golf Club for the 1944 season.

◈ ◈

Dr. Isabelle McTavish, formerly of Newdale, Man., is now located at Bonnevville, Alta.

◈ ◈

Dr. C. D. Shortt has recently been appointed to the Medical Department of the Canadian National Railways.

◈ ◈

It would not be at all surprising to hear some patent medicine manufacturer announce over the Radio that he had discovered a Vitamin that was a sure cure for a disease as yet unknown to mankind.

Dr. J. B. Baker recently at the Winnipeg General Hospital is now practicing at Brandon, Man.

◈ ◈

Dr. E. J. Skafel, formerly of Sarnia, Ont., is now practicing at Brandon, Man.

◈ ◈

Dr. Aaron Magid, formerly of Marsden, Sask., is now practicing at Magrath, Alta.

◈ ◈

Dr. W. T. Dingle has moved from Pine Falls, Man., to Winnipeg.

◈ ◈

Dr. D. L. Johnson of Brandon, Man., C.C.F. standard bearer, was elected in a recent by-election to the Provincial Legislature.

◈ ◈

The Women's Auxiliary to the Royal Canadian Army Medical Corps sent a total of 418 parcels containing 1845 articles to the personnel serving overseas with No. 5 General Hospital, 3rd Casualty Clearing Station and 10th Field Hygiene.

◈ ◈

Dr. Marguerite B. B. Shea, recently on the staff of Victoria Hospital, Winnipeg, is now in Vancouver.

◈ ◈

Dr. and Mrs. F. Gerard Allison are receiving congratulations on the birth of a daughter at the Winnipeg General Hospital on November 25th, 1943.

◈ ◈

Dr. R. M. Cumberland, formerly of Helen Mines, Ont., is now located at Pine Falls, Man.

◈ ◈

Dr. V. F. Onhauser recently returned from a trip to New York City, and Washington, D.C. While in Washington he inspected the New Marine Hospital which is furnished with today's most modern equipment and facilities which are unexcelled.

SQUIBB *can fill your needs for*

INDIVIDUALLY

THIAMINE HYDROCHLORIDE
1, 3, 5 and 10 mg. Microcaps

RIBOFLAVIN
1 and 5 mg. Microcaps

PYRIDOXINE HYDROCHLORIDE
1 and 10 mg. Microcaps

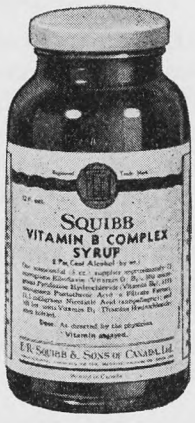
NICOTINAMIDE
50 mg. Microcaps

CALCIUM PANTOTHENATE
10 mg. Microcaps

B-COMPLEX PRODUCTS

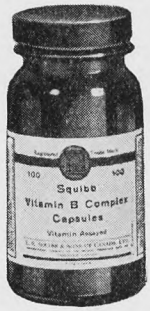
Collectively

SYRUP
•
CAPSULES
•
TABLETS



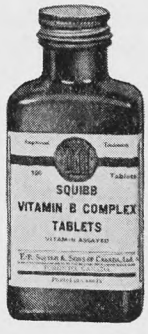
VITAMIN B COMPLEX SYRUP

An extract of the whole natural B-Complex as derived from rice bran, enriched with thiamine hydrochloride and riboflavin.



VITAMIN B COMPLEX CAPSULES

Contains the *whole* natural B-Complex as derived from high potency brewers' yeast, fortified with five crystalline vitamins.



VITAMIN B COMPLEX TABLETS

Made with a special B-Complex *extract* of brewers' yeast fortified with five crystalline vitamins. *Potent and Economical.*

For literature write 36 Caledonia Road, Toronto, Canada.

E·R·SQUIBB & SONS OF CANADA, Ltd.
MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

Manitoba Medical Review

ESTABLISHED 1921

WINNIPEG, DECEMBER, 1943

Published Monthly by the
MANITOBA MEDICAL ASSOCIATION
Canadian Medical Association, Manitoba Division
Editorial and Business Offices
510 MEDICAL ARTS BUILDING, WINNIPEG

Editor
J. C. HOSSACK, M.D., C.M. (Man.)
Associate Editor
R. B. MITCHELL, B.A., M.D., C.M. (Man.), F.R.C.P. (Can.)
J. GORDON WHITLEY, *Business Manager*
Annual Subscription - $2.00

Editorial or other opinion expressed in this Review is not necessarily sanctioned by the Manitoba Medical Association

The New Editor

No reader of the *Review* will need to be instructed on the importance to a journal of its editor. He is its steersman, captain and creator, and in consequence the journal reflects his personality. This is the preface to the announcement that the *Manitoba Medical Review* has changed editors. Dr. Gerard Allison, who has directed its course for some years has resigned, and a new captain is taking over his duties.

Dr. Allison has left his impress on the *Review* and it has been notable. He emphasized the clinical side of medicine, and one could not pick up an issue of that journal without finding at least one article dealing with some disease or lesion that would be met with in general practice. Also he brought to our attention what he had gleaned through his wide reading of current medical journals and presented us with the golden kernel, after winnowing out the chaff.

Dr. J. C. Hossack, who for two years has supplied a sparkling page dealing with the activities of the Winnipeg Medical Society, succeeds Dr. Allison. He will bring his own personality to the *Review,* and we predict that its pages will continue to appeal equally to its readers. Dr. Hossack has a flair for writing, is well read and is keenly interested in medicine, particularly in its neurological and historic aspects.

Ave atque vale.

Editorial

It is written, "of the making of books there is no end," and somewhere there should be one entitled "How to be an Editor." If there be such a book, however, I have not seen it and, as editing is something new to me, I shall have to learn as I go along.

I take it, however, that the chief duty of an editor is to please his readers and, to this end, certain changes have been made.

I am willing to wager that when you saw the bright spot of colour on your desk you looked again, picked it up and thumbed it over. In its former dress of modest grey the *Review* was easily misplaced and not easily found. Now, bury it as deeply as you like among journals and trade magazines, it will still attract your attention and invite your notice.

It is my belief that the *Review* is, for the most part, read in the office and between patients. If that is so, then the articles should be short, immediately helpful and some at least should be entertaining. Each month there will be three short papers, one on a medical subject, one that will appeal to the surgeons and a special article written by some distinguished member of the profession upon whom we have some claim. What luck I shall have in coaxing the "distinguished members" will be revealed in future issues. For this one we have Harry Williams, who numbers among his patients none less than the President of China, Generalissimo Chiang Kai Chek, and his wife.

I have felt for a long time that the doings at Hospital Luncheons deserved wider publicity. This we mean to give them. A number of "reporters"—one in each hospital—will condense each programme given, or, if the subject justifies it, will arrange for a fuller presentation. This will give the country practitioners an opportunity to profit by the Hospital activities and may remind the urban doctors of what they miss by not attending these functions. In order to make it easier to remember the times and places of the professional meetings, we have introduced a calendar of the month's medical happenings. Regarding the Section meetings, remember that they are open to all members of the Winnipeg Medical Society. For "out-of-towners" the calendar will be useful as a means of telling them what meetings are "on" when they come to town. The affairs of the District Societies will, we hope, be reported to us for publication.

The Notice Board, which my friends say they like, will continue to boost the Winnipeg Medical Society, with occasional excursions into the realms of history, philosophy and criticism (of chiropractors). But near to it you will in future find a much more important feature, "The Association Page."

It is the fate of governing bodies to be ignored or decried but seldom to be appreciated and scarcely ever to be praised. The doings of the Manitoba Medical Association Executive in the past have been shrouded in all the secrecy that attends meetings of the War Cabinet. As a result, only those who serve realize how much moiling and toiling goes on at these meetings which often last far into the night.

I have persuaded Dr. Aikenhead to pluck off the bushel under which this light has been hid. It is only fair to the Executive that you should know how they labour for your good and it is only proper that

you should share in and assist their deliberations by reading this important page and venting your feelings upon the topics with which it deals.

Dr. Roy Martin has an idea that something should be done about the "iniquity of oblivion' 'which, as you will recall "blindly scattereth her poppy." Therefore, he is responsible for a series of articles upon the medical pioneers of the Province. Perhaps this may be extended to personal reminiscences by himself and others who began practice in the horse-and-buggy days. These will begin next month.

Many readers prefer the focused attention of a case history to the wider scope of an article and, to serve them, we hope to have each month one or two records of interesting and instructive cases. It is possible that the demand for these may exceed the supply, in which case we hope to fill an otherwise empty page with Clinical-Pathological Conferences.

Each month, then, you can look for so much clinical instrucion that, by the time the year is up, you should have the equivalent of a post-graduate course.

To do this, however, requires contributions. We are all agreed that Winnipeg is one of the principal seats of medical education in the Dominion. If this is so (and no one will deny it) the fact should be reflected in this *Review*. It goes to other provinces and by it we and our school are judged. There should be no dearth of articles nor will there be if those who have the material and the experience will do their duty by us. We are not in competition with the C.M.A. Journal. We want short, interesting, helpful, informal and informative papers of roughly 1000 words. Some of you may find it easier to report a case—then do so, but do something.

There is no reason why this *Review* should not rank at the top of the list of Provincial Association Journals. Let us make it a point of honour to put it there.

Obituary

Dr. Henry John Meiklejohn died at his home in Winnipeg on November 13 at the age of 84. Born in Hastings County, Ontario, he was educated at Campbellford High School and Trinity College, Toronto, where he graduated in medicine in 1888. After post-graduate work in Edinburgh and London he practiced for twelve years at Stirling, Ont. He came to Winnipeg in 1899 as provincial manager for the Federal Life Insurance Company, and later for the Sovereign Life Assurance Company. In 1910 he became managing director of the latter company and in 1926 was appointed president, which office he held till his retirement in 1934. He took a keen interest in community affairs, especially the work of Knox United Church.

Winnipeg Medical Society—Notice Board

C. M. STRONG—*President*
P. H. MCNULTY—*Vice-President*
MEETINGS
Third Friday, each month

C. B. STEWART — *Past President*

Next Meeting
December 17th

W. F. TISDALE—*Secretary*
H. M. EDMISON—*Treasurer*
MEETINGS
Start exactly at 8:15 p.m.

The November meeting began with a reference to the ubiquitous chiropractors in whose breasts there springs an eternal hope of legal recognition. I don't think there is much question that eventually they will get it. People being what they are—unscientific, unreasonable and highly credulous—the siren song of the miracle worker will lure them to a dangerous mirage and they will turn their backs upon the place where lies their real safety. Never before have the public been more familiar with the triumphs of medical science. What schoolboy has not heard about the sulpha drugs and penicillin and anti-toxin? These and many other household words were coined in the laboratories of scientific medicine. Many a grave is still unopened that would, but for medical science, have long since closed upon the bodies of staunch supporters of chiropractors.

And yet with all this evidence before them the people of today, like the Israelites of the past, still go a-whoring after false gods. "In all things relating to disease," said Osler, "credulity remains a permanent fact uninfluenced by civilization or education." The people either cannot see or cannot understand. Perhaps we are ourselves to blame, for by giving them a little knowledge of our practice we may have bred their contempt. Thomas Carlyle, finding sleep hard to woo, leaned his elbows upon the window-sill of his attic and, looking over the roof-tops of London, said, "There lie three millions of people, mostly fools." Upon which the modern gum-chewing, rug cutter, might comment, "Ain't it the truth?"

But, just as the Israelites turned away from Moses and built their golden calf, so do the people today turn to their modern false prophets of health. The question before us is how to render legalized chiropractic innocuous. One way would be to insist upon University control, the student of chiropractic being compelled, as is the medical student, to complete the two premedical, and two or three professional, years of the recognized course. Then, being soundly grounded, he could proceed to fathom the intricacies of spine-punching and solve the mysteries of the neurocalometer.

A second and most important matter is the inclusion of physiotherapy in the medical curriculum. We attack disease with a bottle of medicine in one hand and a knife in the other. The chiropractors go after it with bare fists. No one will deny that massage and mechano therapy generally are of definite value. Only by employing those useful but neglected agents—neglected, that is, by us—can we take from the chiropractors what is good in their practice.

Then there is a third thing. There is much publicity given to the new remedies by medical scientists but little or none devoted to the users of these things. The practice of medicine should be propagandised as well.

At the meeting all that was said dealt with the Committee of Twelve, which is about to go into action upon the matter.

After this affair was disposed of, rosy-cheeked Dr. Baldry told us about the Anti-V.D. Campaign of the Young Men's Section of the Board of Trade and a motion was passed endorsing this campaign. Time changes, doesn't it? The meat of the turkey is "white" or "dark" because Victorian modesty shied at the word "breast," and legs, of course, were "limbs." Now syphilis is quite the proper thing to talk about, and important, too. Do you recall the Irishman's version of God Save the King? "Confound their politics; Frustrate their knavish tricks; *Shut off their 606.*"

Next was read a letter dealing with refugees. You will find it elsewhere in this issue. The idea was to have a petition signed by those at the meeting, but I think everyone forgot about it.

And now to the Scientific Programme. Dr. Rice led off with a very clear, instructive and interesting dissertation on the Electroencephalograph. He showed the large and imposing apparatus which, with technical assistance, he made. It is a most impressive and ingenious contraption.

Then came Dr. Chown's paper on Meningococcus Infection. A hundred million years ago (or it may have been only ten millions, authorities differ) there flourished, in what we now call Germany, a crocodile-like reptile known as Steneosaurus Bollensis. How this ancient teleosaur lived is as conjectural as its age. To us the point of interest is not how it lived but how it died for we can see it, in the stony state of a fossil, lying in an attitude of extreme opisthotonus. Before the dawn of history, in the steaming swamps of the jurrasic, this gigantic lizard thrashed and twisted and bent in its death throes, the victim of living particles of such minuteness that 100 000 of them could find concealment beneath a single grain of dust. For, according to the paleopathologists, disease and not accident wrought this tremendous back-arching.

It was the meningococcus, we are told, that pushed Steneosaurus into the ooze from which, after many

eons, it has emerged as a fossil. No one had ever heard of the meningococcus 57 years ago. For decades after that the knowledge was of value only in the more accurate filling of death certificates. Even until very recently, and especially in epidemics, for one that was left another was taken. How great is the change since then!

Dr. Bruce Chown went back a matter of ten years and showed us how much rosier is the outlook today. Next month you will have an opportunity to read the paper for yourselves in these pages.

As I listened to Dr. Rice and Dr. Chown my mind went back to the topic with which the meeting opened—the chiropractors. One wondered what they did at their gatherings. What peculiar monstrosity passed with them for science. Hippocrates with his calm, philosophic brow, has no room there. In his place is exalted Old Man Palmer, "Fountain-head" Palmer. For the serpent and the rod are instituted the neurocalometer and the cash register. Not Aesculapius but his sister, Circe, the witch-daughter of Apollo, is the source of their afflatus, scarcely to be called divine. Yet many of the people want them and, what is more, believe in them. Verily, as Bacon wrote three and a half centuries ago, "The weakness and credulity of men is such, as they will often prefer a mountebank or witch before a learned physician." To which our gum-chewing, rug-cutting, hep-cat might again add, "Ain't it the truth?" *J.C.H.*

Case Reports

Pelvic Tumors and Pregnancy

by S. KOBRINSKY, M.D.
Lecturer in Obstetrics, Faculty of Medicine, University of Manitoba

Under the scope of this title three cases were presented during the 1943 M.M.A. Convention—at the St. Boniface Hospital session. Two of these cases are dealt with here.

One, was a case of uterine fibroids and pregnancy, the other was a case of ovarian tumor with acute torsion of the pedicle in conjunction with pregnancy. Perhaps a short review of the opinions of recognized authorities may be permissible before actually presenting the cases.

The late Blair Bell[1] claimed that two-thirds of women who have fibroids are sterile. The reasons given are as follows:

(1) Co-existing pathology or distortion in the uterine tubes.
(2) Adenomatous condition of the endometrium with consequent haemorrhage rendering impregnation and implantation of the ovum difficult if not impossible.
(3) If pregnancy does occur there is a greater tendency to abortion.

Johnson[2] in his text book states that about 20% of the pregnant women who have fibroids will abort. He advises that as a general rule these cases should be left alone during pregnancy. During labor—if tumor is large—Caesarian section should be done possibly followed by hysterectomy; under no circumstances should foetus be dragged forcibly past an obstructing tumor.

According to Adair[3] — when fibroids are present abortions and faulty position are frequent. He states that twelve to fifteen per cent of women who have fibroids will have these located in the pelvis. Of these 75 to 80% require surgical treatment before labor is completed.

Curtis[4] says that tumors of the upper part of the uterus usually do not interfere with labor — if they are not large. He generally favors Caesarian section with disposition of the tumors by myomectomy or hysterectomy depending upon the size of the mass or masses.

Case Report

Mrs. D., 33 years old—consulted me July 1941 because of sterility and backache—no pregnancy after being married for over ten years. A thorough systemic and pelvic examination revealed the following relevant factors: weight of patient 88 lbs.; a mild chlorotic type of anaemia, a relatively small and somewhat retroflexed uterus with some slight irregular elevations on its anterior surface and cervix showing a superficial erosion.

The uterine displacement was readily corrected manually; cervical erosion responded well to topical silver nitrate applications. She was given ferrous sulphate and vitamin E by mouth. Patient became pregnant but in April 1942 aborted at 2½ months; there were no untoward sequellae. She again presented herself on November 18th 1942 reporting L.M.P. as of October 3rd to 6th, 1942. She was placed on partial rest and given Vitamin E, progesterone and cod liver oil—all by mouth. Pregnancy continued rather uneventfully. Several small fibroids and one fairly large one could be palpated on the accessible parts of the uterus.

When seen on July 9th, 1943, which was approximately the expected date, position was L.O.A. Presenting part showed no sign of engagement; and manually could not be forced into the true pelvis, *i.e.*, "the cork would not fit the bottle." The external pelvic measurements were E.C. 17½ cm., I.S. 23 cm.,

I.C. 26 cm., R.E.O., 19 cm., L.E.O. 19½ cm. On July 14th classical Caesarean section was performed under gas anaesthesia—a normal 7½ lbs. female foetus was delivered. One large subserous fibroid—about the size of an average orange was excised from the upper and anterior part of the fundus. A few small fibroids were present on the anterior and posterior surfaces of the lower part of the fundus. These—I believe—were responsible for preventing the presenting part to enter the true pelvis and undoubtedly would have made delivery via naturalis impossible. However they were not extensive enough to justify hysterectomy.

Convalescence was rather uneventful except for a mild oedema in the left lower limb with a pyrexia up to 100.2 for a few days. I have seen this patient recently; both mother and child were in good health.

Ovarian Tumors and Pregnancy

The concensus of opinion is that surgical removal is the method of choice in dealing with these tumors.

According to the late Blair Bell[5], even if both ovaries are involved to the extent that they both have to be excised, pregnancy can go on to full term. This does not hold true if the operation has to be performed in the first few weeks of pregnancy.

Johnstone[6] says that in the first half of pregnancy tumors of the ovary should be removed as soon as diagnosed. In the second half of pregnancy they are to be treated surgically only if they are large or have torsion of the pedicle.

Adair[7] states that all ovarian tumors with the exception of the small follicular type should be excised; he also makes the statement that even though the involved ovary contain the corpus luteum pregnancy may continue.

Case Report

Mrs. C.,—24 years of age—consulted me first on April 5th, 1943 because of (1) dysmenorrhea, (2) haemorrhoids, and (3) rather prolonged intermenstrual period, 7/35-42 and wanted to know if it was safe to become pregnant. She had been married 3½ years and never pregnant—said she employed contraceptive measures.

Phy. exam.—well built healthy young woman, wasserman negative; urinalysis negative; uterus somewhat small, adnexa normal. I could find no contra-indication to pregnancy and advised accordingly. I saw her again on June 11th, 1943—her last menstrual period was on April 19th, 1943. P.V. exam.—pregnant. On the morning of June 25th seized with sudden severe crampy pains in left lower quadrant—no nausea, no vaginal bleeding. T. 98, P. 90—no abdominal rigidity. P.V.—mass palpable in left lower quadrant, quite tender. Admitted to hospital, June 25th at 5:30 p.m., T. 100, P. 120. Blood count: leucocytes 11,450 Hgb. 84%, urinalysis-negative. Sedimentation rate index-2. Laparotomy revealed a large purplish mass about the size and consistency of a normal spleen, with a marked torsion of pedicle involving whole of ovarian mass. Ovary excised—uneventful recovery; discharged from the hospital July 6th. This ovary did not contain the corpus luteum. This patient was last seen on November 12th; height of fundus corresponded to extent of pregnancy, foetal heart heard distinctly.

Patient's only complaint was an occasional transitory attack of crampy pains about the umbilicus.

The third was a case of carcinoma of the cervix and pregnancy.

1. Wm. Blair Bell—The Principles of Gynaecology—1934—P. 503.
2. Johnstone—A Text Book of Midwifery—1939. P. 308-9-10.
3. Fred L. Adair—Obstetrics and Gynaecology—1940—Vol. 2—P. 284.
4. A. H. Curtis—Text Book of Gynaecology—1942—P. 258.
5. Wm. Blair Bell—The Principles of Gynaecology—1934—P. 591.
6. Johnstone—A Text Book of Midwifery—1939—P. 308-9-10.
7. Adair—Obstetrics and Gynaecology—1940—P. 334—Vol. 2.

Obituary

Dr. Jules Marie Dugas of St. Pierre, Man., was killed on November 23, while hunting deer in the Brokenhead district of Eastern Manitoba. He was born in Meyronne, Sask., thirty-two years ago; received his degree in arts from St. Boniface College and in Medicine from Laval University, Quebec, and since July had practiced at St. Pierre. He is survived by his mother, stepfather, a brother, Rev. Dominique Dugas, two step-brothers and two sisters.

Association Page

On Questionnaires

The gestation period of a questionnaire is short. Perhaps this is due to its multipaternity. The latter may be of value from a legal standpoint. From the viewpoint of the man on the street, there is safety in numbers. We may pass rapidly over the formative period of a questionnaire. "Mal de mer"—quickening, mental and emotional changes and we arrive at delivery. The delivery is the "bete noir" of those charged with the successful delivery of the questionnaire. "Dystocia" is the rule rather than the exception. What are some of the common causes of questionnaire "Dystocia?" *Procrastination!* This is one of the most serious maladies that affects questionnaires. A perfectly healthy, lusty questionnaire, with crisp, smooth paper, lies evenly upon the busy physician's desk. Each day the little friend is neglected, its condition becomes worse; the hot desiccating atmosphere of the office of a modern "Aesculapius" quickly does its work. In many offices the receptionist either tosses the questionnaire into the wastepaper basket or lays it upon the heightening pile of literature upon the latest vitamin.

AMNESIA—The recipient of a questionnaire has no recollection of its reception. Possibly a slight ripple passes over the cerebral cortex as the questionnaire envelope is opened, but more weighty matters soon blot the impression of something to be attended to. Amnesia is definitely increasing.

LAISSEZ-FAIRE.—This type of dystocia allows nature to take its own course. In this day and age of competition, questionnaires suffer intensely. Laissez-faire may include procrastination, amnesia, even plain laziness.

ENNUI.—What's the use? If all the questionnaires I have filled out, what a bonfire they would make! Another questionnaire is neither here nor there. If they want a reply urgently they certainly will send another one.

AGIN THE GOVERNMENT.—This type of reaction to questionnaires fortunately is in the low percentage category. The recipient is just naturally against everything constructive. Caesarean section is the only way of getting the questionnaire from this type of recipient.

What are the common methods of treating these abnormal questionnaire deliveries? Procrastination responds moderately well to a repeat of the questionnaire, a telephone call, a kindly word dropped between the many acts of kindness a medico performs during his busy day. Lack of any or all of these simple remedies may drag the procrastinator into the amnesia, laissez-faire or ennui class.

Amnesia may occur as the result of defect of (1) Impressibility— amnesia of the anterograde type; (2) Retentive power—amnesia of defective conservation (retrograde); (3) Power of recollection—amnesia of reproduction (retrograde), and lastly—retrograde amnesia of defective recollection. The obstetrical equivalent as an oxyoxic to this type of dystocia is a sharp telephone call.

LAISSEZ-FAIRE—To successfully overcome this type of questionnaire dystocia, one has to use various wiles. A promise to send in the document the next day usually means the postman passes without even an interrogating look. A further brief note meets with no response. Forceps delivery is the usual finish. Our friend smiles blankly as he signs upon the last line. The customer is always right.

ENNUI.—No solution is offered to this distressing condition. A parallel may be suggested—"A normal pelvic inlet but outlet is too narrow for a successful delivery."

Views and Reviews

If you think that Health Insurance discussions are academic, that rugged individualism will continue to flourish in the profession, that the average man is satisfied, no better plan can be evolved than the present system of medical coverage, do nothing. If, however, you, like Marie Antoinette, in the distance, hear the distant rumbling of the tumbrils, which, in this year of Grace, tumbrils to us suggest state medicine.

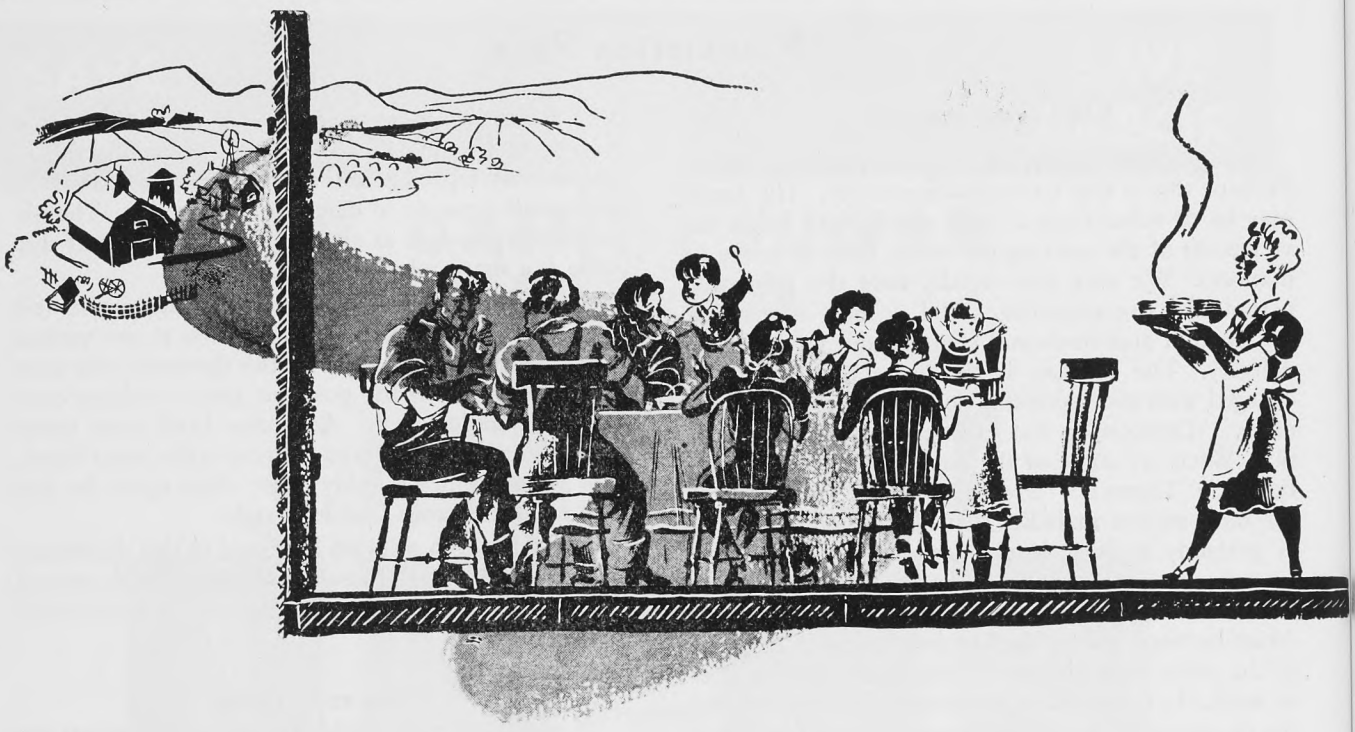
Herewith, an extract of a review of the views of a prominent social worker which recently appeared in a Winnipeg newspaper:

"She thinks the amount for nursing services too low, and the amount for medical fees proportionately too high.

"She would have general health centres, including hospitals and clinics, throughout the Dominion, staffed by doctors and nurses on full-time salary. When talking to Toronto newspaper representatives a few days ago she was asked if she thought her plan would have the co-operation of the medical profession. She believed it would, to a feasible extent, once the scheme was established. Patients could still have their own doctors if they paid them. But for the most part, people would not have choice of doctors; but she said that this was true now in many places, especially in rural districts.

"She was asked if the government could secure the highest type of men on a salary basis, and she replied that Sir Frederick Banting and Sir William Osler both worked on full-time salary.

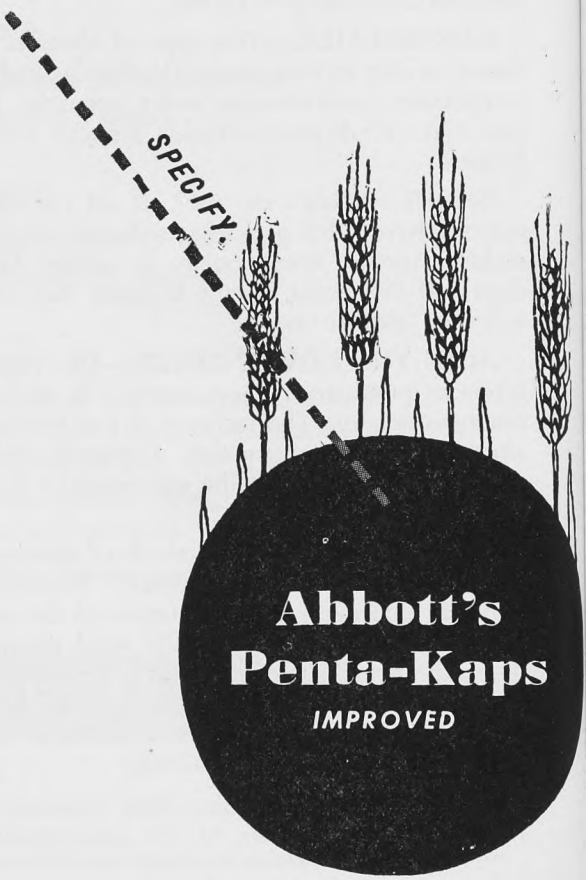
"Right now, the best tuberculosis specialists in Canada are the heads of sanatoria, all salaried men. In fact, T.B. treatment in most of Canada today is already run as a social utility. Out in Saskatchewan, one-third of all towns and cities have the municipal doctor system hiring a man on salary."



Eighty acres of good land

...and STARVATION

Contrary to popular belief, even people living on American farms may suffer from inadequate diets. The physician in rural areas, like his colleague in the cities, is decidedly *not safe* in assuming that his patients are receiving sufficient amounts of all the necessary vitamins. In a majority of cases, of course, in town or country there are no clear-cut clinical symptoms. Studies, show, however, that although the *classical* vitamin deficiency diseases are seldom encountered, *partial* vitamin deficiencies are by no means rare. In such cases, along with correction of the diet, the administration of a vitamin supplement—a *dependable* vitamin supplement—is a rational and timely measure. More and more often, *Abbott's Penta-Kaps* is the brand preferred. Physicians everywhere know that specifying Penta-Kaps on their prescriptions is a simple, certain means of insuring that patients receive all of the vitamin units claimed on the label. Abbott Laboratories, Limited, Montreal.



Department of Health and Public Welfare

Comparisons Communicable Diseases—Manitoba

(Whites Only)

DISEASES	1943		1942		TOTALS	
	Sept. 12 to October 9	Aug. 15 to Sept. 11	Sept. 10 to October 7	Aug. 13 to Sept. 9	Jan. 1 to Oct. 9,'43	Jan. 1 to Oct. 7,'42
Anterior Poliomyelitis	10	7	10	6	33	49
Chickenpox	37	15	49	24	1175	1581
Diphtheria	13	15	31	8	204	172
Diphtheria Carriers	1	1	8	1	19	16
Dysentery, Amoebic	....	1	....	....	7	....
Dysentery, Bacillary	1	2	....	2	12	8
Erysipelas	4	4	3	8	53	77
Encephalitis	2	2	5	8	8	34
Influenza	5	3	16	5	379	197
Measles	86	88	19	27	2632	4329
German Measles	3	....	1	....	171	263
Meningococcal Meningitis	....	....	1	2	26	22
Mumps	64	54	42	38	3205	2730
Ophthalmia Neonatorum	....	....	....	....	....	1
Pneumonia—Lobar	2	2	5	1	132	90
Puerperal Fever	....	....	....	....	1	2
Scarlet Fever	81	45	30	21	1083	1111
Septic Sore Throat	1	3	1	1	38	60
Smallpox	....	....	....	....	....	....
Tetanus	....	....	....	2	1	3
Trachoma	1	....	....	1	3	5
Tuberculosis	50	42	39	59	485	444
Typhoid Fever	....	4	11	8	22	27
Typh. Para-Typhoid	....	....	....	....	3	2
Typhoid Carriers	....	1	....	....	2	1
Undulant Fever	....	1	2	....	7	10
Whooping Cough	74	74	109	48	1617	360
Gonorrhoea	137	127	115	121	1438	1126
Syphilis	43	34	47	54	416	566
Meningococcal Carriers	....	....	....	....	6	....

	Oct. 10 to Nov. 6	Sept. 12 to October 9	Oct. 8 to Nov. 4	Sept. 10 to Oct. 7	Jan. 1 to Nov. 6,'43	Jan. 1 to Nov. 4,'42
Anterior Poliomyelitis	2	10	12	10	35	61
Chickenpox	175	40	270	49	1353	1851
Diphtheria	10	15	36	31	217	208
Diphtheria Carriers	2	1	14	8	21	30
Dysentery, Amoebic	....	....	....	....	7	....
Dysentery, Bacillary	2	1	3	1	16	11
Erysipelas	2	4	3	3	57	80
Encephalitis	1	2	4	5	9	38
Influenza	2	12	4	16	393	201
Measles	78	86	16	19	2712	4345
Measles, German	....	3	....	1	171	263
Meningococcal Meningitis	4	1	1	1	31	23
Mumps	112	71	59	42	3324	2789
Ophthalmia Neonatorum	....	....	....	....	....	1
Pneumonia, Lobar	3	4	3	5	137	93
Puerperal Fever	1	....	....	....	2	2
Scarlet Fever	144	83	53	30	1236	1164
Septic Sore Throat	....	1	....	1	38	60
Smallpox	....	....	....	....	....	....
Tetanus	....	....	....	....	1	3
Trachoma	....	1	....	....	3	5
Tuberculosis	53	50	38	39	538	482
Typhoid Fever	1	....	4	11	23	31
Typhoid Paratyphoid	....	....	....	....	3	2
Typhoid Carriers	....	....	....	....	2	1
Undulant Fever	1	....	1	2	8	11
Whooping Cough	72	78	94	109	1693	454
Gonorrhoea	134	137	118	115	1572	1244
Syphilis	60	43	74	47	476	640
Meningococcal Carriers	....	....	....	....	6	....
Actinomycosis	....	....	....	....	1	....

DEATHS FROM COMMUNICABLE DISEASES
September, 1943

URBAN—Cancer 44, Tuberculosis 6, Pneumonia (other forms) 5, Syphilis 5, Pneumonia (lobar) 3, Erysipelas 1, Lethargic Encephalitis 1, Puerperal Septicaemia 1, Dysentery 1, Hodgkin's Disease 1, Septic Sore Throat 1. Other deaths under 1 year 27. Other deaths over 1 year 151. Stillbirths 12. Total, 259.

RURAL—Cancer 28, Tuberculosis 8, Pneumonia (lobar) 6, Pneumonia (other forms) 5, Influenza 1, Lethargic Encephalitis 1, Whooping Cough 1, Tetanus 1, Dysentery 1. Other deaths under 1 year 17. Other deaths over 1 year 136. Stillbirths 10. Total 215.

INDIANS—Tuberculosis 12, Influenza 3, Measles 2, Pneumonia (other forms) 2. Other deaths under 1 year 3. Other deaths over 1 year 7. Stillbirths 1. Total 30.

Department of Health and Public Welfare

DISEASE	Manitoba Sept. 12-Oct. 9 *737,935	Ontario Sept. 12-Oct. 9 *3,824,734	Saskatchewan Sept. 12-Oct. 9 *905,974	Minnesota Sept. 12-Oct. 9 *2,792,300	North Dakota Sept. 12-Oct. 9 *641,933
Anterior Poliomyelitis	10	33	18	64	4
Meningococcal Meningitis	....	18	4	8	2
Chickenpox	37	234	70	....	....
Diphtheria	13	2	1	32	7
Dysentery, Amoebic	....	....	....	3	....
Dysentery, Bacillary	1	....	....	1	....
Erysipelas	4	5	3	....	2
Influenza	5	59	....	3	34
Encephalitis	2	....	....	....	....
Measles	86	205	20	305	343
German Measles	3	18	4	....	....
Mumps	64	178	27	....	51
Rocky Mtn. Spotted Fever	....	....	....	....	1
Puerperal Fever	....	1	1	....	....
Scarlet Fever	81	215	64	147	31
Septic Sore Throat	1	1	....	....	....
Smallpox	....	....	....	1	1
Trachoma	1	....	2	....	8
Tuberculosis	50	202	53	25	26
Tularemia	....	1	....	....	1

* Approximate populations.

DISEASE	Manitoba Oct. 10-Nov. 6 *737,935	Ontario Oct. 10-Nov. 6 *3,824,734	Saskatchewan Oct. 10-Nov. 6 *905,974	Minnesota Oct. 10-Nov. 6 *2,792,300	North Dakota Oct. 10-Nov. 6 *641,933
Anterior Poliomyelitis	2	11	....	28	4
Meningococcal Meningitis	4	15	2	8	1
Chickenpox	175	820	195	....	32
Diphtheria	10	6	4	35	7
Erysipelas	2	6	2	....	....
Influenza	2	81	....	....	17
Encephalitis	1	....	2	....	1
Measles	78	786	11	1110	622
German Measles	....	44	3	....	12
Mumps	112	442	17	....	12
Ophthalmia Neonatorum	....	2	....	....	....
Puerperal Fever	1	1	....	....	....
Scarlet Fever	144	357	84	287	39
Septic Sore Throat	....	8	....	....	2
Trachoma	....	....	....	....	2
Tuberculosis	53	203	28	2	19
Typhoid Fever	1	4	....	1	2
Typhoid Para-typhoid	....	2	1	....	....
Undulant Fever	1	11	....	14	....
Whooping Cough	72	522	108	192	60

* Approximate populations.

New Evidence on the Effect on the Infant of the Mother's Diet During Pregnancy

(Taken from the Sept., 1943 issue of *The Child.*)

Contrary to usual obstetric teaching, the adequacy of the mother's diet during pregnancy has a direct effect upon the physical condition of her infant, according to evidence presented by Bertha S. Burke and others, in a report entitled "Nutrition Studies During Pregnancy." This paper is one of a series reporting on a 12-year research programme on the growth and development of the well child, undertaken by the Department of Child Hygiene, School of Public Health, Harvard University.

As a step toward solving the problem of the extent of the dependence of the fetus upon the maternal diet, the authors studied the diets of 216 women in relation to (1) physical condition of the infant; (2) course of pregnancy—especially with regard to pre-eclampsia; (3) duration and character of labor and type of delivery; and (4) complications of the post-partum period.

The relationship between the adequacy of the mother's diet and the condition of the infant was found to be more marked than that between the diet and the course of pregnancy. "This indicates," according to the report, "that with an inadequate prenatal diet the fetus suffers to a greater degree than the mother. In other words, the fetus is parasitic upon the mother only to a certain extent, and that extent is limited apparently by the mother's nutritional state at the time she enters pregnancy and by the quality and quantity of her diet during pregnancy. "It is of the utmost importance to realize this fact," say the authors, "because in the usual clinical examination during pregnancy it is not possible to evaluate adequately the condition of the fetus, and it is entirely possible that a woman may have an apparently satisfactory clinical course, but if she is consuming an inadequate diet the fetus will suffer."

The conclusions of the study are as follows:

1. This study has shown a statistically significant relationship between the diet of the mother during pregnancy and the condition of her infant at birth.

2. If the diet of the mother during pregnancy is poor to very poor, she will in all probability have a poor infant from the standpoint of physical condition. In the 216 cases studied, every stillborn infant, every infant who died within a few days of birth (with the exception of one), the majority of infants with marked congenital defects, all premature, and all "functionally immature" infants were born to mothers whose diets during pregnancy were very inadequate.

3. If the mother's diet during pregnancy is excellent or good, her infant will probably be in good or excellent physical condition. However, it may happen occasionally (1 out of 216 cases in this series) that a mother whose diet during pregnancy was "excellent" or "good" will give birth to an infant in poor physical condition.

4. A statistically significant relationship was found to exist between prenatal diet and the course of pregnancy. This relationship, however, is not as marked as that existing between the prenatal dietary rating and the condition of the infant. This indicates that

when the nutrition during pregnancy is inadequate, the fetus suffers to a greater degree than the mother.

5. In this study, no mother whose diet during pregnancy was considered "good" or "excellent" had pre-eclampsia, while with a "poor to very poor" diet during pregnancy almost 50 per cent had preeclampsia.

6. No statistically significant associations were found to exist between prenatal nutrition and the duration and character of labor and delivery. There was a tendency for the mothers whose diets during pregnancy were "poor to very poor" to have more difficult types of delivery and have more major complications at delivery, despite the fact that these women had, on the average, smaller infants than were born to the women whose diets were "good" or "excellent."

7. No relationships of statistical significance were found to exist between prenatal nutrition and the postpartum course. There seemed to be a tendency toward relationship between prenatal nutrition and the occurrence of major complications in the puerperium.

Stature of Canadian Children

(Taken from *"Canada, 1943"*)

The health teaching that has been emphasized in schools during recent years appears to be contributing to a considerable increase in the stature of Canadian children. Recent measurements of 80,000 children in Toronto schools compared with similar measurements in 1923, show that children of ages 7 to 13 years now average from one to two inches taller. Five-year-olds are more than half an inch taller; fourteen-year-olds are taller now than fifteen-year-olds were then. Corresponding increases are shown in weight.

These records indicate that Canadian children are considerably taller and heavier than English or Scottish and slightly above those United States children that have been measured in recent surveys. There are probably few countries engaged in the present war where conditions have affected as little the health and growth of children as in Canada, thanks to freedom from enemy occupancy or attack, and the relatively abundant food supplies that have been available.